What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

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THE BRAINS BEHIND THE GAINS

What Works (WW): What is the link between CHFP and CHPS?

Prof. Fred Binka[1] (FB): One thing no one ever realises is that the CHFP experiment was not directed at CHPS. That was not the goal. The experiment was to find out how to improve family planning (FP) uptake in a rural setting like Navrongo. The service delivery component only came in when we realised that it was indispensable to the success of FP promotion.

WW: How did it all begin?

FB: At about 1992/93 the idea came up that there was a huge demand for FP but there were no supply outlets. It was thought that a trusted person in the community could supply contraceptives to satisfy this unmet need. That is how the Community-based Distributors (CBD) system started. It was this type of experiment that USAID was going to fund. The original CHFP study started in Bolgatanga District. The report was titled "Let our children live first".. It was a multi district FP uptake study for which Dr. Odoi Agyarko, Dr. Sam Adjei and others had done preliminary work. Through Jim Phillips of the Population Council we got wind of it. We advised that they needed an innovation—a service delivery component, but the Ministry and the sponsors were not interested in funding that. Their aim was to supply commodities. For example, USAID was not willing to pay for the Motorbikes for the CHOs. They thought that was a big commitment. The first motorbikes were therefore bought by the Rockefeller Foundation. The full range of PHC was incorporated and we took precautions to ensure that FP was in the front seat. Unexpectedly, when the project took off the other components of health service delivery took the front seat and family planning took the back seat even though it was one of our main outcome measures. Now everyone is talking about service delivery, about CHPS, and not FP.

Professor Fred Binka looking at CHPS with a different pair of lenses

WW: What was the Ministry's role in the CHFP?

FB: The Ministry's role at the beginning was very obstructive. Their major concern was that they did not want us to run an experiment whose results would not be useful. Secondly, they were not willing to allow community health nurses to treat patients because they have only been trained to provide promotive and preventive care. So there was a lot of debate.

WW: What really was your point?

FB: Our argument was that in rural communities people cannot differentiate between a nurse who provides preventive care and one who provides treatment. If a child is sick the nurse cannot say 'well, I have not been trained to treat malaria'. We also drew inspiration from the Ministry's own concept of choosing people from the community and training them to treat minor ailments. Based on this we said we could also retrain the community health nurse but the Ministry was adamant. We insisted that as a research institution we had the mandate to try things out in order to inform policy. We have been vindicated; today nobody is batting an eye about community health nurses going to communities to treat people.

WW: Certainly the Ministry needed to be sure that it would work?

FB: I agree but I tell you what, the world has moved on. Currently the biggest disease in this country is malaria. Even at the World Health Organisation level there is an agreement that malaria treatment should be at the home. So programmes are out there to help mothers treat malaria, how much more a health worker?

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[1] Professor Binka was Director of NHRC and PI at the launch of the CHFP. He is presently the Executive Director of INDEPTH.

WW: Somehow, it looks like this country is not prepared for CHPS.

FB: No. It is not that people are not prepared for CHPS. CHPS in one way or the other has been tried before in this country. But CHPS is like any other national programme; it does not get off the ground until someone brings in a huge sum of money.

WW: So what's unique about this one?

FB: What is unique about CHPS is that it is the first home-grown intervention that we have developed ourselves. It is not something that was found somewhere and a donor is trying to introduce in Ghana.

WW: If CHPS is our family drum, why are there problems in beating it?

FB: We had demonstrated CHFP in a carefully monitored and controlled setting in the Kassena-Nankana district in Northern Ghana. There are other issues that needed to be addressed at the regional level before we went countrywide. I have always advocated that the first thing to do would have been to scale up the CHFP in the whole of Upper-East region and learn some of the lessons in trying to move the CHFP beyond the district. Fortunately Nkwanta had also demonstrated that Navrongo was replicable in other parts of Ghana using resources within the system.

WW: What can Navrongo do to help CHPS move?

FB: Navrongo should continue to set the modalities for implementing CHPS and research into common problems of implementation. Cooperating Agencies are now providing technical support for something they have not done anywhere in the world. Why should someone else be giving us technical support for something we ourselves developed? It is Navrongo which should be providing that kind of support.

WW: Does it have to do with who pays the piper calling the tune?

FB: Absolutely! But you shouldn't completely blame our development partners alone. The Ministry, which should have been projecting Navrongo, is not doing it. I have been at meetings on CHPS where Navrongo is not even mentioned. I have been one of the key people who designed the project but I sit here in Accra and when there are meetings concerning CHPS I am not even invited! We have spent valuable time since 1993 tinkering with the idea till we got it right. You cannot say someone arrives now from somewhere and understands it better. There are many problems we went through that have not even been documented.

Binka estimating the size of the problem

WW: What were some of the problems?

FB: When we started CHFP, it took some communities three months to start. You know how long it took the longest community? **Two and half years!** The thing is, communities work at their own pace. Their major preoccupation in life is to find food and then shelter before they think about health. If I tell you the processes we had to go through to make sure all the communities were part of the programme you would marvel.

WW: What is the way forward?

FB: I believe charity begins at home though it must not end there. Why can't Navrongo for instance go to the [Upper-East] regional health administration and tell them 'look, we have demonstrated that this thing works, we have the expertise, and we can help you move CHPS into the other five districts'. There is no reason why you would not get attention. If Navrongo can do this for the Upper-East, before long you would be in a position to help Upper-West, Northern region, and the rest.

WW: Who gave you a push when you needed it most?

FB: There are quite a good number of names but I can't mention all of them here. Dr. Moses Adibo's contribution was outstanding—he gave us all the political support to get CHFP off the ground. He had been Regional Director of Health Services in the Upper-East region so he readily understood what we were trying to do. But just when we were about to start he went on retirement but he continued to guide us with his experience.

WW: What are your impressions about the What works? What fails? newsletter?

FB: It represents a brilliant step by Navrongo to tell the whole world about one of its most remarkable research findings. Navrongo deserves congratulations for the good work done.

Send questions or comments to: What works? What fails?
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